DOCUMENT RESUME

ED 316 350 PS 018 654

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TITLE Improving Maternal and Child Health: A Legislator's Guide.
INSTITUTION Child and Family Policy Center, Des Moines, IA.
PUB DATE Jan 90
NOTE 51p.
AVAILABLE FROM Child and Family Policy Center, 100 Court Avenue, Suite 312, Des Moines, IA 50309 ($0.50).
PUB TYPE Guides - Non-Classroom Use (055)

EDRS PRICE MF01/PC03 Plus Postage.
DESCRIPTORS Check Lists; *Child Health; *Federal Programs; Guidelines; *Health Services; Home Visits; Innovation; Insurance; Malpractice; Mothers; Program Evaluation; *Program Improvement; State Legislation; *State Programs
IDENTIFIERS Early Periodic Screening Diagnosis Treatment Prog; Family Policy; *Maternal Health; Medicaid; Women Infants Children Supplemental Food Program

ABSTRACT

This legislators' guide outlines state maternal health programs and strategies and offers states options for improving their maternal and child health services. The introductory chapter 1 is followed by an overview of maternal and child health status in the United States in chapter 2. Costs associated with the failure to provide adequate prenatal health care services are considered. Chapter 3 describes federal programs that provide health services to pregnant women and children. Recent congressional changes to the Medicaid program are covered. Chapters 4 and 5 describe state initiatives to improve maternal and child health. Chapter 4 discusses state initiatives to enhance the provision of perinatal health care services through changes to the state Medicaid program. Chapter 5 covers other state initiatives for improving maternal and child health services. These include options for use of maternal and child health block grant funds; the Women, Infants, and Children program; and Early Periodic Screening Diagnosis and Treatment services for children under Medicaid. Chapter 6 offers a framework that state policymakers can use to develop state strategies to improve maternal and child health services. The appendix includes a checklist for policymakers to use in identifying gaps in state maternal and child health programs. (RH)

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Improving Maternal and Child Health: A Legislator's Guide

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CHILD & FAMILY POLICY CENTER

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Dear State policy maker:

States and the federal government both have recognized the need to develop programs and policies to improve maternal and child health services in this country.

As a result, states have enacted a rich array of programs to achieve this end– some dealing with improving financial access to health services and some seeking to enrich the health services that are provided.

This guide briefly outlines many of these state initiatives and offers options states might wish to explore in improving their maternal and child health services. This guide also describes current federal programs and program options, including the new federal Medicaid requirements enacted by the U.S. Congress in 1989 and effective upon the states on April 1, 1990.

While every effort has been made to use current state information in this guide, state activity is so substantial in this area that the information becomes dated very quickly. The Child and Family Policy Center encourages comments from policy makers for changes or additions to this guide, for subsequent editions.

Above all, the Child and Family Policy Center hopes this guide will be useful in reviewing state program efforts and considering new program options.

Sincerely,

Charles Bruner,
Executive Director

Improving Maternal and Child Health: A Legislator's Guide

By Charles Bruner,
Child and Family Policy Center

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Acknowledgements

The author would like to thank Mary Lee Allen, Larry Bartlett, Megan Berryhill, David and Charlotte Bruner, Kathy Bryant, Pat Butler, Ian Hill, Martha King, Dick Merritt, Kathryn Moore, Marilyn Musser, Doug Nelson, Sara Rosenbaum, Shelley Smith, and Michele Solloway for reviewing earlier drafts of this guide and for making many helpful comments and suggestions. Jan Trantnor and Joseph Liu provided additional valuable information. These comments and suggestions greatly improved the quality of the guide, but any remaining shortcomings clearly rest with the author.

1.

Introduction

When twenty-five-year-old Ollie Hill of Detroit gave birth to a four-pound baby on June 9, 1987, she had had no prenatal care. While her baby was on a heart monitor in the thousand-dollar-a-day intensive care unit of Hutzel Hospital, Ms. Hill told of being unmarried and unemployed and unable to pay for a doctor's visit during her pregnancy. Also, she said, based on the experience of her prenatal care during her first pregnancy, the trip wouldn't have been worth the effort.

"You wait four hours to see the doctor for five minutes," she said. "He just pokes at your stomach and tells you everything's okay."

This quote from Lisbeth Schorr's excellent book, Within Our Reach, clearly illustrates some of the obstacles women like Ollie face in obtaining appropriate health care services. Further, it warns that public policy solutions to inadequate prenatal care, low birthweight, and infant mortality must be sensitive to these different types of obstacles and develop strategies to surmount them.

Obviously, Ollie faced problems with financing her prenatal care (although it is possible that she was eligible for

Medicaid, but was unaware of her eligibility). It is to this particular obstacle that much recent state and federal activity has been directed.

In addition, however, Ollie faced many other potential obstacles. She may have had to take a long bus ride to get to a physician or clinic to obtain prenatal care, with no provision for child care for her other child while she was gone or means to cover the transportation expense. She may have had to search to find a physician or clinic that provided prenatal health services for her, even if she was eligible for Medicaid. She may not have had anyone to answer her nonmedical questions or address her nonmedical needs during pregnancy, or a health care practitioner who could answer her health questions in terms she related to. She may not have been able to afford to purchase some of the things that would have been recommended for her during pregnancy, had she been provided that advice. Her housing situation and physical environment themselves may have placed her at risk. She may have had no social supports to relieve her of the strain of parenting her other child while seeking employment. In short, she may have faced a variety of obstacles that a Medicaid card alone would not have solved. Had these obstacles been surmounted and prenatal care provided, however, she may have given birth to a child of normal birthweight who did not incur thousands of dollars of hospital expenses after birth.

Fortunately, there now exist a number of state initiatives that can serve as models for meeting the varieties of health and health-related needs that women like Ollie have. This guide provides an overview of many of these initiatives.

This guide has been written with state legislators in mind, although it should benefit other state policy makers and child health policy advocates as well. State legislatures are becoming increasingly sophisticated in their approach to health care issues generally, and to developing maternal and child health program initiatives in particular. Many of the innovative programs cited in this guide were initiatives developed by legislators.

Because this guide is directed to state legislators, it is designed to give a quick overview of many different program options, with specific state programs highlighted which can be

contacted for further information. A checklist in the Appendix of this guide is for legislators to use to contrast their state program efforts with those undertaken in other states.

Legislators and other state policy makers will have to explore in more detail specific program models before enacting legislation to initiate new services. This guide offers no model legislation. Similarly, program implementation, a key to achieving program success, is not covered in this guide, although legislators must be careful to fashion programs that will be implemented effectively. Finally, this guide does not address the private insurance market, although many states have taken action to assure that individual and group health insurance programs cover maternal and child health benefits.

Instead, this guide serves as a quick reference point to identify promising new strategies that legislators can explore for potential adaptation to the needs of their states. It suggests the broad array of strategies that states should consider in seeking to improve their maternal and child health services.

Chapter Two of this guide provides an overview of maternal and child health status in the United States, including some of the costs associated with failing to provide adequate prenatal health care services.

Chapter Three briefly describes federal programs that provide health services to pregnant women and children, including the most recent Congressional changes to the Medicaid program. Most state initiatives covered in this guide build upon these federal programs, and, in particular, seek to make maximum use of the Medicaid program and its matching federal funding.

Chapters Four and Five describe specific state initiatives to improve maternal and child health. Chapter Four discusses state initiatives to enhance the provision of perinatal health care services through changes to the state Medicaid program. Chapter Five discusses other state initiatives to improve maternal and child health services, including options available for use of maternal and child health block grant funds, the WIC program, and EPSDT services for children under Medicaid.

Chapter Six offers a framework that state policy makers might use in developing state strategies to improve maternal and child health services. As mentioned previously, the Appendix includes a checklist for policy makers to use in identifying gaps in their states' health care programs for pregnant women and children.

This guide has been developed in the belief that state legislators and other state policy makers know that women like Ollie Smith live in their states and want to develop a more responsive health care system for them. The fact that so many promising state and state-federal initiatives have developed over the last few years is evidence of the validity of this belief. The challenge many state legislators now face is how best to fashion their state programs to surmount the obstacles women like Ollie Smith face in getting appropriate health services. It is hoped that this guide will be of use to meeting this challenge.

2.

The Status of Maternal and Child Health in the United States

In 1986, the United States ranked eighteenth worldwide in infant mortality, with a rate of 10 deaths per 1,000 live births [see Table I]. In 1950, the United States had ranked sixth among twenty industrialized nations in infant mortality rates, but had fallen to last place among these nations by 1980, surpassed by nations whose infant mortality had been double that of the United States thirty years earlier. In 1986, the incidence of infant mortality for blacks in the United States, at 18 per 1,000 live births, was double that for whites. In 1986, nearly 40,000 babies in the United States died before their first birthday.

Sobering statistics such as these led the Surgeon General of the United States, in 1980, to call for an infant mortality rate of no more than 9 deaths per 1,000 live births by the year 1990, with no racial or ethnic group having an infant mortality rate higher than 12 deaths per 1,000 live births. Despite improvements in neonatal intensive care services throughout the 1980's, however, it is clear that these goals will not be reached by 1990. Current goals set by the United States Public Health Service-- an infant mortality rate of no more than 7 deaths per live births by the year 2000, with no racial or ethnic group having an infant mortality rate higher than

Table I

Infant Mortality Rates, Selected Countries, 1986

Rank	Country	Rate
1	Japan	6
1	Finland	6
1	Sweden	6
4	Denmark	7
4	Switzerland	7
4	Norway	7
7	Netherlands	8
7	France	8
7	Canada	8
10	Hong Kong	9
10	Singapore	9
10	German Dem. Rep.	9
10	Belgium	9
10	Germany, Fed. Rep.	9
10	United Kingdom	9
10	Spain	9
10	Ireland	9
**	**U.S. (White)**	**9**
18	Austria	10
18	Australia	10
18	**UNITED STATES**	**10**
21	Italy	11
21	New Zealand	11
23	Greece	12
24	Israel	14
24	Czechoslovakia	14
26	Cuba	15
26	Bulgaria	15
28	Poland	18
28	Hungary	18
28	Portugal	18
28	Costa Rica	18
**	**U.S. (Black)**	**18**

Note: Rates are deaths per 1,000 live births. Source of international information is UNICEF. Reproduced from: Hughes, Dana, et.al., The Health of America's Children (Children's Defense Fund: 1988).

11 deaths per 1,000 live births– will be reached only if very significant improvements are made in the provision of prenatal care, particularly to low-income and at-risk populations.

Infant mortality, and a variety of disabilities and chronic health problems, are strongly associated with low birthweight and lack of adequate prenatal health care. Roughly two-thirds of infant deaths occur among low-birthweight infants (those weighing less than 2,500 grams or approximately 5 1/2 pounds at birth). Low-birthweight infants are almost forty times more likely to die during their first four weeks of life than are normal birthweight infants.

After decreasing during the 1970's, the percentage of low-birthweight infants to all births remained virtually unchanged from 1980 to 1985, and the slight gains that occurred in reducing infant mortality rates during that period were largely attributable to the use of high cost medical technology in neonatal intensive care settings. More than $ 2.5 billion annually is spent in the United States on intensive hospital care for sick newborns, much of that associated with complications due to low birthweight.

In addition to infant mortality and neonatal hospitalization, low birthweight is associated with a variety of long-term disabilities. Low birthweight infants are three times more likely than normal birthweight infants to experience neurological problems such as cerebral palsy and seizure disorders. It has been estimated that about 11,000 low birthweight babies annually suffer from avoidable long-term disabilities, including mental retardation, cerebral palsy, blindness, seizure disorders, developmental delays, and learning disabilities. State governments spend hundreds of millions of dollars annually for the cost of neonatal intensive care services under Medicaid and other public health programs. Moreover, the financial responsibility generally falls upon the states to provide long-term habilitation and rehabilitation services for disabled persons through state health services, special education funding, foster care, and institutionalization and family support.

The great human and financial costs associated with low birthweight are particularly tragic, because they are often preventable. It is known that the problems and expenses

associated with infant mortality and low birthweight babies are related to lifestyle and often can be averted with proper nutrition and prenatal care. Women who smoke are at much greater risk of giving birth to low birthweight babies than those who refrain from smoking during pregnancy, and drinking and drug use during pregnancy can have very serious adverse consequences on infant health, although pregnant women may be unaware of these potential consequences. National studies have documented that mothers who receive no prenatal care are three times as likely to have low birthweight babies. A 1986 report issued by the Institute of Medicine indicated that for every dollar spent on providing prenatal care for high-risk, low-income women, as much as $ 3.38 worth of intensive medical care for high-risk infants can be averted, and this is simply the short-term savings from avoided neonatal expenditures.

Early and comprehensive prenatal care also leads to savings beyond the first year of life. The U.S. Congress Office of Technology Assessment estimates that "for every low birthweight birth averted by earlier or more frequent prenatal care, the U.S. health system saves between $ 14,000 and $ 30,000 in newborn hospitalization, rehospitalizations in the first year, and long-term health care costs associated with low birthweight."

Despite this knowledge, however, only sixty-eight percent of all pregnant women receive what can be considered "adequate" prenatal care by a widely used measure (care beginning in the first trimester of pregnancy and including nine or more health care visits for a pregnancy of thirty-six or more weeks). The proportion of infants born to women receiving late or no prenatal care actually rose in the first half of the 1980's– from 5.1 % of all women in 1980 to 5.7 % of all women in 1985.

Eligibility for Medicaid alone, while a critical first step, is no guarantee of adequate prenatal care. According to one recent survey, while 81 % of privately insured women receive adequate prenatal care, only 36 % of Medicaid insured women do, only slightly above the 32 % rate for uninsured women [see Table II]. While the Medicaid program can provide extensive prenatal coverage, these figures suggest that Medicaid often has been used only late during pregnancy or

Table II

Adequacy of Prenatal Care by Source of Payment--

Results of a 1986-1987 GAO Study

(Uncomplicated Pregnancies)

	Percent Receiving Type of Care		
Source of Payment	Inadequate	Intermediate	Adequate
Privately Insured	2 %	17 %	81 %
Medicaid Covered	16 %	48 %	36 %
No Health Insurance	24 %	44 %	32 %

NOTE: Pregnancies are classified by the Institute of Medicine's prenatal care index in the following manner: adequate if it begins in the first trimester and includes nine or more visits for a pregnancy of 36 or more weeks; intermediate if it begins in the second trimester or includes 5-8 visits for a pregnancy of 36 or more weeks; inadequate if it begins in the third trimester or includes 4 or fewer visits for a pregnancy of 34 or more weeks. Uncomplicated pregnancies are used in this table, as the appropriate number of visits for complicated pregnancies is a matter of medical judgment beyond the ability to condense into a table of this sort. Wide variations did exist among localities included in the survey in the degree to which Medicaid assured access to adequate prenatal care.

Source: United States Government Accounting Office. Prenatal Care: Medicaid Recipients and Uninsured Women Obtain Insufficient Care (GAO Report HRD 87-137: Washington, D.C.: 1987)

only to pay the hospital bills associated with delivery and not to provide adequate prenatal care. Its potential to pay for adequate prenatal care has not yet been realized. Since recent Medicaid expansions for pregnant women, if fully implemented by the states, could cover approximately forty percent of all U.S. births, there has been growing interest and activity at both the state and the national levels in improving the program's prenatal performance.

State legislators increasingly have come to recognize that maternal and child health programs can improve the utilization of appropriate and effective health services and therefore control the use of high cost medical interventions. Since prenatal services represent a prevention program that can avert high cost medical interventions within a short period of time (frequently within the same legislative budgeting cycle), state legislatures have moved quickly to expand their Medicaid programs to improve services to pregnant women.

Related to this focus on prevention, considerable interest also exists in providing primary and preventive health services for children, and particularly low-income children. Early screenings, immunizations, and dental care-- when rigorously pursued for children who otherwise would not receive care-- all have been demonstrated to reduce the incidence of later health problems for those children.

Again, however, recent statistics for the United States are not encouraging. The number of two-year-olds without immunizations for polio, measles, rubella, mumps, and diphtheria actually rose between 1980 and 1985, creating increased possibilities for outbreaks of those diseases. Only four of five two-year-olds in the United States have been immunized for those diseases, compared with the Surgeon General's goal of nine of ten two-year-olds by the year 1990. The early periodic screening, diagnosis, and treatment (EPSDT) program under Medicaid-- while technically available to all children covered by Medicaid and one source for obtaining immunizations-- is currently provided to fewer than one-third of all children on Medicaid. As with infant mortality, the death rates for children in the United States are higher than those for other advanced, industrial societies, although these differences are largely attributable to a high incidence of fatal accidents among U.S. children.

3.

Federal Programs to Serve Pregnant Women and Children

The federal Medicaid program has long been a means for financing maternal and child health medical care, but until recently eligibility for services had been tied to eligibility for the Aid to Families with Dependent Children (AFDC) program. In the last five years, however, federal changes have severed this connection and considerably expanded state coverage opportunities. Changes to Medicaid under the Omnibus Budget Reconciliation Act of 1986 (OBRA-86 or SOBRA), the Consolidated Reconciliation Act of 1986 (COBRA), and the Omnibus Budget Reconciliation Act of 1987 (OBRA-87) all have provided significant new options to states for serving pregnant women and children. These include options to expand the number of pregnant women and children a state may serve, options to ease and streamline entry into the program, and options to expand the array of services available to such pregnant women and children. In addition, requirements under the Medicare Catastrophic Coverage Act of 1988 and the Omnibus Budget Reconciliation Act of 1989 (OBRA-1989) have required states to expand their eligibility levels for pregnant women, infants, and children up to age six up to 133 % of the federal poverty level.

Under OBRA-86, Congress took the first major step in severing the traditional link between Medicaid eligibility and

eligibility for cash assistance by allowing states to do several things: (1) extend Medicaid coverage to pregnant women and their infants in families with incomes up to the federal poverty level; (2) provide coverage for children below the federal poverty level, beginning with children up to age one and phasing in children one year at a time up to age five, (3) waive or liberalize the amounts allowable under resource and assets tests for pregnant women and infants, and (4) establish presumptive and continuous eligibility for pregnant women.

OBRA-87 expanded upon the reforms in OBRA-86 by allowing states to raise income eligibility thresholds for pregnant women and infants as high as 185 percent of the poverty level and allowing states to cover, on a yearly phased-in basis, all children up to age eight in families with incomes up to the poverty level. Additionally, OBRA-87 allowed states to by-pass the phase-in of children created in OBRA-86 and immediately cover children up to age five and then phase-in coverage up to age eight in yearly increments.

Under the Medicare Catastrophic Coverage Act of 1988, by July 1, 1990, all states were required to extend Medicaid coverage to all pregnant women and infants up to age one who live in families with incomes at or below the poverty level, even though they may meet neither the categorical nor the financial eligibility criteria of a state's AFDC program. This action, however, was superseded one year later by a new federal mandate. **In the Omnibus Budget Reconciliation Act of 1989 (OBRA-89), Congress now requires all states, by April 1, 1990, to extend Medicaid coverage to pregnant women, infants, and children up to age six who live in households with incomes up to 133 % of the federal poverty level.** Even states which had previously taken advantage of all federal options find themselves, under this new mandate, required to expand their Medicaid coverage to children from age one up to age six, who fall between 100 % and 133 % of the federal poverty level, as prior to OBRA-89 such children were ineligible for Medicaid coverage. **In addition, OBRA-89 establishes certain additional service requirements for state Medicaid programs, which are identified in boldface in later sections of this guide.**

With respect to service options, COBRA amended the Medicaid program to allow states to provide pregnant women

with extra or "enhanced" services, such as waiving comparability standards that require state Medicaid programs to provide the same amount, duration, and scope of service to all recipients. In addition, COBRA allowed states to provide case management services, including outreach efforts, patient referral, and coordination of services, to pregnant women and to other special Medicaid populations. Under this provision, states are given broad latitude in defining case management to extend beyond the strict confines of the medical model. The only restrictions on the provision of case management services are that states must define the case management services to be provided, the target groups and geographic areas where the services will be provided, and the educational and professional qualifications the providers must have.

The actions of the 1989 Congress in extending mandatory coverage under Medicaid in OBRA-89 represented a last-minute compromise. Many forces are still at work to extend mandatory coverage beyond the 133 % level. Additional federal action in this area is a distinct possibility. Congress also has come to recognize the growing need to address issues related to drug-exposed infants, and particularly to infants born to cocaine-using mothers. These issues also will be of importance to states in fashioning maternal and child health policy.

In addition to Medicaid, the federal government provides substantial support for pregnant women and infants under the Maternal and Child Health block grant, community and migrant health center funding, and funding for the Supplemental Food Program for Women, Infants, and Children (WIC).

The Maternal and Child Health (MCH) block grant program, which incorporates the previous Title V Maternal and Child Health program initiated in 1935 under the Social Security Act, provides grants to states for maternal and child health services to reduce infant mortality. States may determine the services to be provided, with the exception that inpatient care is restricted to "high risk" women and certain children. In 1989, $ 554 million was appropriated for the MCH block grant, and states used a portion of their allocations for free or subsidized prenatal care in public health clinics, health education, outreach to pregnant women, and

transportation services. The expanded eligibility under Medicaid gives states the opportunity to cover some populations under Medicaid that previously were served with MCH funds, thereby freeing those MCH funds to serve other people.

Over 650 Community and Migrant Health Centers (C/MHCs) operate nationally as private, nonprofit organizations funded by the federal government to provide a broad range of primary care services to low-income families. These centers are located in rural and urban communities designated as medically underserved because of low physician/population ratios, high infant mortality rates, high community poverty rates, and other factors. They are required to provide or arrange for the delivery of perinatal services. It is estimated they provide perinatal care to 120,000 women annually. In 1989, Congress appropriated $ 481 million to C/MHCs, including funds to improve and expand the maternal and infant care services the C/MHCs provide.

A final, major federal program designed to improve the health and nutrition of low-income pregnant and nursing women and infants and young children is the Supplemental Food Program for Women, Infants, and Children (WIC), which provides nutrition counseling and food supplements to qualifying families. While states administer the program, WIC requires no state or local match, although states may supplement the WIC program. While Congress appropriated $ 1.929 billion in 1989 to the states for the WIC program, that amount is sufficient to serve only 40 % of potentially eligible women and children, and states must establish their own priority guidelines for WIC participation in order to stay within federal fund allocations.

4.

Innovative State Strategies Using Medicaid To Improve Perinatal Care

New federal options under Medicaid have enabled states to initiate a number of innovative programs to improve maternal and child health. While most legislators are aware of the ability to extend eligibility for Medicaid to more pregnant women and children, states also have options to improve prenatal care through making the system easier to access and more "user friendly," through enhancing the services provided under Medicaid to pregnant women and children, through developing marketing and outreach programs, through increasing provider participation, and through coordinating Medicaid services with other programs and benefits. State program initiatives in each of these areas are described below.

EXTENDING MEDICAID ELIGIBILITY

States have been quick to take advantage of the extended eligibility options available under OBRA-86 and OBRA-87, and a number have gone considerably further than some of the mandates that will be in effect on April 1, 1990.

o By July 1, 1989, forty-four states and the District of

Columbia had raised the income eligibility level for pregnant women and infants up to at least 100 % of the federal poverty level. All states, under OBRA-89, will be required to extend such eligibility to pregnant women and infants up to at least 133 % of the federal poverty level.

o A number of states already have exceeded the new federal mandate for Medicaid coverage of pregnant women and infants up to 133 % of the poverty level. Taking advantage of federal options to do so, California, Connecticut, Hawaii, Iowa, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, New York, Rhode Island, South Carolina, Vermont, and Washington have raised their eligibility level for pregnant women and infants to 185 % of the federal poverty level. Florida, Kansas, and North Carolina have adopted 150 % of the federal poverty level.

o Thirty-six states have extended Medicaid eligibility to children in poverty at least up to age two. Arizona, Arkansas, Florida, Iowa, Louisiana, Maine, Massachusetts, Tennessee, Vermont, and West Virginia have gone at least to the age of five for children in families living below the federal poverty level. Under OBRA-89, states will have to cover, by April 1, 1990, all children up to age six up to 133 % of the poverty level. States still retain the option to cover six and seven year-olds up to 100 % of the poverty level, and seven of the previously-mentioned states have elected this option.

o Forty-two states eliminated any assets requirements for pregnant women and infants to become eligible for Medicaid coverage, and several other states substantially raised or relaxed their asset limitations. Several states eliminated the assets test after determining that the administrative costs of retaining such a test were greater than any savings the test would provide. Determining assets is one of the most complicated parts of a Medicaid application, and one most prone to creating "error rates" and administrative delays or denials of applications on administrative, rather than substantive, grounds. As such, assets tests have provided significant obstacles to women entering care early during pregnancy.

MAKING MEDICAID MORE "USER FRIENDLY"

A number of initiatives have been undertaken by states to make the Medicaid system easier to use and more responsive to eligible pregnant women and children. These have involved changes both in the way families are enrolled and the manner in which the program is presented.

o **Twenty-four states** provide for a "presumptive" eligibility determination for pregnant women so that Medicaid coverage begins immediately upon initial application, if a women appears to meet eligibility criteria. Presumptive eligibility assures a woman of coverage prior to verification of all information, while full application reviews are conducted. It guarantees providers payment during that period, regardless of the final determination of eligibility, and thus assures that prenatal care commences immediately.

o A number of states have taken additional action to assure that women receiving presumptive eligibility status also complete the regular eligibility application for Medicaid in a timely fashion. **Arkansas, Michigan, Pennsylvania,** and **Utah,** among other states, schedule appointments with departmental workers for permanent Medicaid eligibility determination as soon as presumptive eligibility is established. **California, West Virginia,** and **Missouri** flag applications for Medicaid from pregnant women for priority eligibility determinations, with specific timelines for completing this process. **Minnesota** requires county offices that receive inquiries from pregnant women to set an appointment for a face-to-face interview within five days and, after the interview has taken place, to make a final determination of eligibility within ten days of that interview.

o **Forty-one states** provide "continuous" eligibility for pregnant women, which assures that Medicaid coverage will continue through birth and the post-partum period even if a change in income or resources otherwise would have made the family ineligible. This guarantees providers of care continuity in payment, and gives pregnant women assurances that payments will be made for maternity care.

o Four states in particular-- **California, Florida, South Carolina,** and **Tennessee**-- have made significant efforts to

"outstation" Medicaid eligibility workers at sites where providers deliver primary care and pregnant women are likely to receive care, such as hospital prenatal clinics, state and local health department clinics, maternal and child health clinics, and community and migrant health centers. This "outstationing" allows eligibility determinations to commence at the time clients first come for medical help and helps reduce transportation obstacles that otherwise would exist for clients seeking Medicaid coverage. **Delaware, Oklahoma, Mississippi,** and **Utah** also have developed demonstration sites to test the effectiveness of outstationing eligibility workers.

o Several states have developed much shorter Medicaid application forms for clients eligible under the provisions of OBRA-86, especially those states that have eliminated the assets test for this population. **Florida** reduced its application from twelve pages to a single page, with that form used not only to determine eligibility for pregnant women under OBRA-86 but also for initial eligibility determinations for all other federal public assistance programs except food stamps. **West Virginia** reduced its application from twenty pages to three pages for pregnant women; **Delaware's** application was reduced from twenty-six to four pages; and **Minnesota's** from six to three pages. Shorter application forms not only make application for service simpler, they also are likely to reduce state "error rates" for incorrect determinations of eligibility and reduce administrative delays in processing applications that sometimes serve to deny applicants coverage they deserve.

ENHANCING MEDICAID SERVICES

The range of services a state Medicaid program covers may have much to do with the quality of care received by pregnant women and children, and a number of states have adopted initiatives to enhance their service coverage for pregnant women and children.

o In 1979, as a pilot project, **California** established an obstetrical outreach and access program that conducted outreach to low-income pregnant women and provided an expanded array of services for those women, including nutritional counseling, psycho-social assessment, and case

management and supervision to assure that continued prenatal care occurred. Following the results of a study that showed a savings of nearly $ 2 in reduced neonatal intensive care costs for every $ 1 expended on the program, this outreach and access program was expanded statewide. California's program was influential in Congressional action to establish the enhanced service provision options in COBRA, and was used by Iowa in the development of its outreach program in 1988.

o **Michigan** developed a new program of maternal support services as a "pregnancy-related service" under Medicaid in 1987. The state's prenatal care package has been augmented to include referral for and receipt of "maternal support services" (MSS) which are aimed at addressing psychological and nutritional factors that could adversely affect pregnancy outcomes. Michigan has defined such services as "preventive health services of a nonmedical nature which are delivered by a specially certified agency." Specifically, MSS offers childbirth and parenting education, psycho-social and nutrition related assessments, and counseling and transportation services.

o Following a nine-county pilot program of case management for pregnant and parenting teens, **New York** implemented a statewide program of case management services to Medicaid eligible pregnant and parenting teens. The Teenage Services Act (TASA) case management program requires local service districts to offer case management to adolescents who are under 18, receiving AFDC or home relief, and who are pregnant or parents. At their discretion, local districts may offer case management to adolescents at risk of becoming parents. The case management services are designed to help the adolescent obtain needed services and assistance, with an emphasis upon developing a plan for them to become self-sufficient. Specific case management activities include outreach and identification of eligible youth; assessment with the client of her needs and capabilities; development of a plan and goals; services assistance, including identification, referral, and brokering; re-evaluation of the goals and plan; and development of a network with other agencies and providers.

o **Arkansas** has developed a similar expansion package that includes risk assessment, case management, perinatal

education, social services consultation, nutritional counseling, and early discharge home visiting. Of particular interest in the Arkansas program is the provision of up to six classes of perinatal education and an early discharge home visit. The expanded services can be provided by a physician or by a local county health unit.

o Altogether, nineteen states have adopted some enhanced prenatal services for case management within their Medicaid programs similar to those described for California, Michigan, New York, and Arkansas. Sixteen of these include nutritional counseling; eleven include psycho-social assessments and counseling; and eleven provide for home visits.

o Two states-- California and Michigan-- provide vitamin supplements for pregnant women as part of their enhanced services. A number of other states provide such supplements to all their Medicaid-eligible population, upon physician recommendation, but a number of states do not cover such prescriptions.

o Many states provide reimbursement for such prenatal services as sonograms and amniocentesis, but many do not. Wide variation exists among states in the coverage of general medical services available for pregnant women and infants. Mississippi, for instance, recently raised its limit on Medicaid-reimbursable hospital care for children from fifteen to thirty days to ensure that lengthy stays for low birthweight newborns were covered.

o Most states allow reimbursement for at least monthly physician visits for pregnant women during pregnancy, although some states maintain limits on physician visits for all Medicaid recipients that extend to pregnant women as well.

DEVELOPING EFFECTIVE MARKETING AND OUTREACH PROGRAMS

In addition to expanding the coverage available for health services to pregnant women, several states have developed, often with matching Medicaid funds, outreach and marketing programs to increase pregnant women's

participation in prenatal care.

o **North Carolina** has established a vigorous outreach program, which is coordinated with Medicaid case management services that include assistance with eligibility, risk assessment, case plan development and referral, and follow-up and monitoring. The case manager contacts all human service organizations for client referrals, conducts personal interviews and assessments, and follows the client to service completion. The program estimates it reaches ninety percent of the targeted population, and has an active evaluation component.

o **Utah** provides transportation and outreach to eligible pregnant women as part of case coordination and enhanced prenatal services. In addition, Utah also launched a highly regarded multi-media education effort, entitled "Baby Your Baby," including a television campaign donated as a public service by a local television station.

o A number of states have "renamed" their Medicaid program expansions to pregnant women and children under OBRA to eliminate the "welfare" stigma the Medicaid program has for some clients. Program names distinct from Medicaid, even if they are based largely upon Medicaid funding, are perceived as less stigmatizing by some potential users of the program services. In addition to Utah's "Baby Your Baby" program, the **District of Columbia** has "The Better Babies Project," **Massachusetts** the "Healthy Start Program," **Rhode Island** the "Rite Start" program, **Mississippi** the "Baby Showers" program, **Colorado** the "BabyCare" program, **North Carolina** the "Baby Love" initiative, **Michigan** "Maternal Care," and **Pennsylvania** the "Choice" (Concern for Health Options, Information, Care, and Education) campaign.

o Many states have instituted a toll-free 1-800 number for their programs, to help answer queries about the Medicaid program as it affects pregnant women. Such services also can provide the states with feedback about the effectiveness of the types of outreach efforts they use.

o In three states, there exist specific outreach strategies that "reward" programs for finding and enrolling pregnant women in the programs. **Michigan** has employed

paraprofessionals, under the supervision of a health department professional, in targeted communities to find and bring pregnant women into the prenatal care system. Arizona has appropriated funds to support four community-based pilot projects to organize lay community volunteers to conduct outreach to pregnant women. New York has targeted funds to community-based outreach efforts in six areas of the state with the worst infant health indicators and also stressed use of culturally appropriate outreach workers indigenous to the community.

INCREASING PROVIDER PARTICIPATION

Participation in prenatal care also is dependent upon a pregnant woman's ability to find a health care professional willing to provide perinatal services. In some states and geographic areas within states, this has proved to be a problem. Medicaid reimbursement rates for physician services, set by states, vary considerably and may affect the willingness of physicians to serve Medicaid clients. A recent Alan Guttmacher Institute report showed that in 1985, while physician fees averaged $ 830 for a vaginal delivery and $ 1,040 for a Cesarean delivery, the average Medicaid reimbursements were $ 544 for a vaginal delivery and $ 767 for a Cesarean delivery, with variations among high and low states of over $ 800 for each delivery. To encourage broader participation, a number of states have sought to increase their reimbursements to physicians, and some have extended Medicaid reimbursements to additional providers of maternal health care such as nurse midwives. Under OBRA-89, states must submit a plan amendment by April 1 of each year, beginning in 1990, describing state Medicaid rates for obstetrical and pediatric services, with the Secretary of the U.S. Department of Health and Human Services reviewing those rates to determine if they are reasonable and sufficient to insure adequate provider participation in the Medicaid program.

o A number of states have implemented dramatic increases in physician payments for prenatal and obstetrical care. At the same time it expanded its coverage level for pregnant women to 185 % of the poverty level, Mississippi raised its payment for maternity care from $ 341.25 to $ 531.20

and instituted an aggressive patient outreach program. New Hampshire raised its payment level by between $ 390 and $ 566, depending upon the provider's specialization, for maternity services. Rhode Island doubled its reimbursement rate to $ 750, and West Virginia more than doubled its reimbursement-- from $ 225 to $ 600.

o Over half the states have implemented changes in reimbursement policies under Medicaid or in maternal and child health staffing policies to encourage greater use of nurse midwives and nurse practitioners in providing prenatal care.

o Iowa in 1988 included birthing centers as an eligible provider to receive reimbursement under Medicaid.

COORDINATING MEDICAID WITH OTHER PROGRAMS

To remain healthy, poor pregnant women and children may require services and support that extend beyond traditional medical care. Outstationing workers and providing case management services can assist in coordinating such programs. In addition, however, states can make efforts to integrate maternal and child health services, WIC benefits, food stamp benefits, and other services with Medicaid eligibility. **OBRA-89 requires state Medicaid plans, by July 1, 1990, to provide for coordination between the Medicaid and WIC programs, including notifications of Medicaid-eligible pregnant women, nursing mothers, and families with children under age five of the availability of WIC benefits.** Several state programs have sought to facilitate additional levels of coordination at the local level.

o The Iowa General Assembly directed three areas of the state (Ottumwa, Sioux City, and Waterloo), to establish special collaborative agreements that allow public health, human services, and specialized child health clinics to do joint outreach services and provide common intake proceedings for maternal and child health services-- including Medicaid, food stamps, WIC benefits, homemaker health-aides, and well-baby visits. Normally, obtaining these services would require separate trips to several agencies. Such collaboration is aided by the emphasis in Iowa upon co-locating services and

developing interagency agreements to provide single points of entry and eligibility determinations for clients. These programs also operate mobile units that provide outreach services to rural parts of the state.

o **Florida** has established an Improved Pregnancy Outcome (IPO) program that includes the following components: (1) medical risk assessment of preterm labor, with women designated as high risk receiving intensive services that include care from the same physician, weekly visits after twenty-four weeks of pregnancy, nutritional counseling, education to identify signs of preterm labor, and both prenatal and postnatal home visits, (2) a statewide training program for service providers, and (3) inter-program coordination to ensure that IPO staff also conduct EPSDT screening of infants, automatically refer eligible women to WIC with program recertification at postpartum visits, and provide Medicaid application through the IPO staff.

o In 1989, **South Carolina** increased its Medicaid reimbursement to physicians providing perinatal care, if they also provide enhanced services including referral to WIC, health education, parenting education, and family planning. Physician reimbursement for newborn assessments in the hospital also was increased if the assessment includes appropriate referrals to WIC, Medicaid, and home visits.

5.

Other State Strategies to Improve Maternal and Child Health

While Medicaid program expansion is a key component of any state strategy to improve maternal and child health, states have taken other actions both to reduce infant mortality and morbidity and to improve the health of low-income children. Included in such efforts are: providing financial assistance to supplement the maternal and child health block grant and community and migrant health centers, supplementing the WIC program, improving child health services through EPSDT, developing home visiting programs, addressing the malpractice issue, supporting other prenatal care providers, and supporting other health programs. Under OBRA-89, effective April 1, 1990, states must provide Medicaid coverage for ambulatory services provided to Medicaid clients at federally-qualified health care centers, including C/MHCs and programs providing health care for the homeless. Further, states must pay 100 % of these programs' reasonable costs.

PROVIDING STATE SUPPORT TO MCHS AND C/MHCS

Federally-funded maternal and child health programs

(MCHs) and community and migrant health centers (C/MHCs) have proved effective in delivering primary and preventive care services to low-income pregnant women and children. A number of states have provided state support to augment their services.

o **Indiana** and **Iowa** recently appropriated new state funds to supplement the federal MCH block grant and extend the level of direct service coverage that can be provided under that program. In addition, Iowa added funds to the MCH centers in its state to pay the cost of physician referrals and prescription drugs for MCH clients, and to support MCHs to do active follow-up and outreach in assuring that clients make and keep appointments at the centers.

o A number of states, through the state primary care network (SPCA) or their cooperative agreement, provide assistance to MCHs and C/MHCs in maximizing their revenues under Medicaid and assuring that Medicaid is billed for all appropriate services.

SUPPLEMENTING THE WIC PROGRAM

Since the federal Supplemental Food Program for Women, Infants, and Children (WIC) is sufficient to serve only a portion of all potentially eligible WIC recipients, several states have chosen to provide state funds to supplement the WIC program. States have also used other means to assure that federal funding will be extended as far as is possible in reaching WIC clients.

o **Indiana** and **Michigan** recently joined eight other states by providing a separate state appropriation for WIC in order to serve more women and children. **Minnesota** provides a $ 1,000,000 state appropriation to serve 1,200 to 1,500 additional Minnesotans under WIC. Since Minnesota provides state supplemental funding, Minnesota recipients may use their WIC coupons at farmers' markets as well as at regular grocery stores.

o In 1988, five states– **Alaska, Arizona, Iowa, New Jersey,** and **Rhode Island**– had a contingency fund available for the state WIC program in the event unprojected increases

in use of the program might otherwise force a dramatic reduction in client eligibility at the end of the fiscal year. Iowa, for instance, maintains a contingency appropriation to its department of public health so that the department can set eligibility standards for WIC that will assure full use of all available federal funds. Prior to the contingency appropriation, the state had generally reverted WIC funds to the federal government, as department officials could not spend more than their federal allotment and required a cushion against unanticipated expenditures. The contingency appropriation has made Iowa better able to use its entire allotment of federal WIC funds.

o Most, but not all, states now negotiate with infant formula manufacturers and distributors for "rebates" to the WIC program that can be used to serve more clients under WIC. Aggressive negotiations for state contracts with infant formula manufacturers and distributors can extend the effective value of a state's WIC program by millions of dollars. While some states negotiate for a sole source contract, Washington and Iowa have been successful in obtaining state rebates with all infant formula manufacturers and therefore do not restrict WIC clients to one or another of the available infant formulas.

IMPROVING THE STATE EPSDT PROGRAM

In addition to being able to expand Medicaid coverage to children up to eight years of age who live in poverty, states have a number of options available to improve child health services, particularly through creative use of the early periodic screening, diagnosis, and treatment (EPSDT) program under Medicaid. State use of EPSDT varies widely-- from fewer than ten percent of eligible children screened through EPSDT in some states to more than fifty percent screened in other states. Under OBRA-89, Congress established several provisions specifically designed to intensify state EPSDT efforts. Beginning in July, 1990, the Secretary of the U.S. Department of Health and Human Services must set annual EPSDT participation goals for each state and states must report on the number of children receiving EPSDT services. States must provide services to treat physical or mental problems identified through EPSDT, even if those services

are not covered under the state's Medicaid plan. Screening must include health education, dental screenings before age five, and blood testing, as appropriate. Under previous actions, the federal government has given states unusual flexibility in fashioning their EPSDT programs, and some states have taken great advantage of this flexibility.

o **Wisconsin** has developed a computer-assisted outreach program as part of its Health Check (EPSDT) program. Through a monthly review of Medicaid claims history, Wisconsin identifies, in order of priority, children who have received no care at all, those who have received only episodic emergency care, teens who have received no preventive care, and children who have received no dental care. Lists of those children are forwarded to contract outreach providers (local public health departments and some nonprofit health providers) who conduct outreach efforts under interagency contracts with the Medicaid program. The outreach workers are paid on a per capita basis for each child who gets screened. This action helped Wisconsin double its EPSDT screening rate. In contrast to many other states, where the EPSDT screening is weak on developmental and psycho-social components, Wisconsin's EPSDT program includes a family interview and a parental concerns questionnaire that often provide information that assists in making needed mental health referrals.

o In **Vermont**, public health nurses and health outreach workers do EPSDT outreach as well as perform other public health functions such as WIC home visits and public health-sponsored postpartum visits. Services provided under "Partners in Health," Vermont's name for its EPSDT program, include education on preventive health care, preliminary assessments of a child's medical status and needs, information and referral to other community resources, and assistance with scheduling visits and transportation. A significant portion of the EPSDT outreach is done through home visits, which are used as an opportunity for health education and individual case plan development for each client and family.

o **South Carolina** has made its EPSDT program the joint activity of the State Health and Human Service Finance Commission and the State Departments of Social Services and Health and Environmental Control. The county departments

of social services receive Medicaid reimbursement for EPSDT case management, which includes informing eligible families, scheduling screening, arranging for transportation, and referring nonparticipating children to outreach workers. Under a similar Medicaid contract, the Department of Health and Environmental Control employs outreach registered nurses who receive referrals and make home visits to the children and their families. During the home visits, the nurses perform a general health and social assessment, provide information on health programs, and encourage parents to participate in EPSDT. South Carolina reports that screening rates have doubled as a result of the EPSDT case management and outreach program.

o **Georgia** and **Colorado** have implemented models similar to South Carolina's in which local health department staff function as designated outreach workers under a Medicaid contract. Colorado also contracts with local Headstart programs for EPSDT outreach and case management. **Arkansas** has strengthened its EPSDT case management and outreach functions by using registered nurses on the staff of the state Medicaid agency, with those staff responsible for tracking eligible children and performing outreach through home visits.

SUPPORTING HOME VISITING PROGRAMS

In addition to the inclusion within some Medicaid programs of a home visiting component for pregnant women and nursing mothers, states and communities have developed and financed home visiting programs independent of the Medicaid program. Many hospitals throughout the country also provide such services. Home visiting programs can be highly successful in improving maternal and infant health status, as they can detect environmental risk factors in the home that can endanger healthy infant development. Further, visits do not create transportation or child care obstacles for the families served, but allow for more relaxed and informal exchanges of information about perinatal care and parenting. Several states have provided financial support and direction to home visiting.

o In 1977, **Kansas** initiated its Healthy Start-Home

Visitor program, now funded by the legislature. Kansas' program employs lay visitors to visit all new mothers to offer parenting skills support, to link families with services, to encourage preventive and well-child checkups, and to recognize the need for and make necessary referrals. Supervised by the local health department nurses, the home visitor program conducted visits with over 14,000 families in 1988, one-third of all new families. The program now also targets high-risk families for services, including pregnant teens and pregnant women with histories of poor health or problem pregnancies.

o Following a recommendation of the Virginia Task Force on Infant Mortality, Virginia established Resource Mothers programs in a number of locations within the state in 1985. These programs involve home visitors trained in health, social services, and counseling and are supervised by a public health nurse. With a focus upon pregnant teenagers, the Norfolk program has caseloads of seven to fifteen teenagers per resource mother, and actively works to get teenagers into early prenatal care; reduce or eliminate unhealthy behaviors such as smoking or drinking; prepare teenagers for labor, delivery, and the needs of the newborn; and keep teenagers in school during pregnancy. As a result of the program, the low birthweight rate for adolescents using the Norfolk program has been more than 50 % below the statewide rate for adolescents.

o The Elmira, New York, Prenatal and Early Infancy Program is one of the oldest and best documented home visiting programs and initially was a very intensive program, including many home visits with families during pregnancy and until the infant reached two years of age. While the program, due to funding problems, has become considerably less intensive, it has obtained Medicaid funding support. Research from the initial, intensive program showed dramatic successes in reducing low birthweight, reducing infant abuse and neglect, reducing the likelihood of future unplanned pregnancies, and keeping adolescent mothers in school.

MITIGATING THE IMPACT OF MALPRACTICE INSURANCE COSTS

High and rising malpractice premiums frequently have

been cited as affecting the availability of physicians willing to provide obstetrical services, particularly in rural areas. Several states have revised their liability statutes specifically to address obstetrical care issues, in the hopes that such revisions will reduce the cost of liability coverage and increase the availability of obstetrical care.

o In 1986, **Hawaii** established a special fund to help cover liability insurance premiums to attract obstetric providers to underserved areas of the state. **Arizona, North Carolina, Texas,** and **Washington** more recently established funding for such subsidies. Typically, these subsidies are calculated according to a formula based upon a ratio of Medicaid and indigent cases to the total patient caseload, in order to assure that those most in need of services are accepted into care.

o In 1987, **Virginia** expanded its good samaritan law to provide obstetrics providers with immunity from liability for providing voluntary, emergency delivery services. Designed to address a major concern of obstetricians– that of the drop-in patient ready for delivery and about whom no prenatal medical history is available– such good samaritan clauses are not without controversy and have usually been very narrowly drafted. In addition to Virginia, **California, Montana,** and **North Dakota** have some form of good samaritan drop-in delivery immunity.

o In 1987, **Missouri** allowed the state, rather than the physician, to assume liability in malpractice claims in certain circumstances. In modifying its tort claims act, Missouri assumed liability for obstetrical services the physician agreed to provide free or with minimal compensation from the city, county, or state. **Texas** and **West Virginia** have established their own versions of state indemnification for indigent patient obstetrical cases.

o **Virginia** and **Florida,** in actions yet to be tested constitutionally, have established no-fault liability for a narrowly defined class of catastrophic, birth-related injuries that are responsible for extremely high pay-outs in obstetrical cases. Analogous to worker's compensation, an infant injury compensation fund is the substitute for the tort system for these catastrophic, birth-related injury cases.

SUPPORTING OTHER PERINATAL HEALTH CARE PRACTITIONERS

In addition to seeking to ease the malpractice burden faced by physicians and therefore encouraging more physicians to provide obstetrical care, states also have looked to supporting other health practitioners in providing perinatal care services. **OBRA-89 now requires states to provide Medicaid coverage for certified pediatric or family nurse practitioner services, even if there is no physician supervision.**

o In 1989, **Arkansas** created a grant program for nurse midwife students entering accredited schools, with grants forgiven after the nurse midwife practiced at least two years in medically-underserved communities in the state. Similar initiatives for nurse practitioners have proved more successful in deploying health practitioners in medically-underserved areas than have most physician deployment incentives.

o In 1989, **Connecticut** established a nurse midwife licensure system within its department of public health. Licensure requires certification by the American College of Nurse Midwives and thirty hours of education in pharmacology for nurse midwifery. Nurse midwives are required to have a clinical practice relationship with an obstetrician gynecologist that includes protocols including a list of medications, devices, and laboratory tests that the nurse midwife may prescribe, dispense, or administer.

SUPPORTING OTHER HEALTH PROGRAMS

In addition to supporting the programs described above, several states have augmented other public or private health programs to improve maternal and child health. Some have chosen to provide coverage to pregnant women and children that extends considerably beyond any of the existing federal Medicaid program eligibility options.

o In 1989, **Minnesota** expanded its Child Health Plan to provide free primary, preventive, and outpatient mental health services to all low-income children under eighteen and up to 185 % of the federal poverty level. Minnesota has expanded

this state program while taking full advantage of Medicaid program eligibility options.

o **The Maine** Health Program, enacted in 1989 and scheduled to begin in July, 1990, covers children in households with incomes below 125 % of the federal poverty level under state-sponsored health insurance coverage, with participants from households with incomes above the poverty level paying a portion of the insurance premium.

o **Hawaii** in 1989 enacted legislation requiring that uninsured residents have access to primary and preventive health services and appropriated $ 14 million over the FY 90-91 biennium for the program. Although Hawaii requires all employers to provide health coverage, an estimated 50,000 people remain uninsured, including many children, as the employer mandate does not require employers to cover workers' dependents.

o **The District of Columbia** expanded the availability of affordable prenatal care by eliminating fees in its clinics for uninsured pregnant women with incomes below $ 20,000.

o **New Jersey**, under a hospital-based managed care system, now provides prenatal care services free of charge to all women with incomes up to 250 % of the federal poverty level who give birth and lack medical insurance. Financed through the state's uncompensated care trust fund, the program, entitled "Jersey MOMS" (Maternal Outreach and Managed Services), will provide free health and nutrition services and counseling and home visits to women up to 150 % of the poverty level, and seven check-ups during pregnancy to all women in the program.

o Blue Cross/Blue Shields in Pennsylvania, Alabama, Iowa, Maryland, Missouri, and North Carolina have established programs to provide health care services to low-income children through voluntary, private sector contributions. Provider discounts are sought to augment the program impact. In 1989, **Iowa** contributed state funding to Blue Cross/Blue Shield of Iowa's "Caring Foundation." Iowa's state funding is predicated on a four-to-one private match by 1992 and requires the "Caring Foundation" to coordinate its service with other public providers of care.

6.

Conclusion

This guide has identified a variety of innovative state strategies for improving maternal and child health, particularly for low-income families. Each state will have to determine for itself what approaches are appropriate to its political culture, service configuration, and service needs.

In examining state efforts to improve maternal and child health care and the health outcomes for low-income families, this guide has stressed the following key points:

o Low-income pregnant women and children face barriers to receiving adequate health care services that can be addressed through state efforts and that can improve pregnancy outcomes and infant and child health. With respect to perinatal health care, these improved outcomes can prevent the need for substantial immediate expenditures for costly neonatal intensive care services.

o While important, expanding Medicaid eligibility to more pregnant women and children through new federal eligibility options does not in itself guarantee improved access to health care. A variety of other obstacles within a state's Medicaid program may exist to limit the access of pregnant women and children to appropriate and needed health care.

o States have many options in fashioning Medicaid

programs that can affect client participation, provider participation, and the effective use of health services by Medicaid recipients. Wide variations exist among state programs in the degree to which they take advantage of these Medicaid program options.

o States also can improve the health of pregnant women and children through direct support of public health programs such as maternal and child health services and community and migrant health centers and through support for such health-related services as the Supplemental Food Program for Women, Infant, and Children (WIC).

o Service coordination is essential to assuring that low-income pregnant women and children receive the range of services to which they are entitled. States need to consciously fashion programs to encourage interagency collaboration and service coordination, as many health-related services provided to pregnant women and children cross agency boundaries.

In developing specific state initiatives, state legislators and other state policy makers at a minimum should do the following:

o Identify state goals and targets for improving maternal and child health and reducing infant mortality and the incidence of low birthweight infants.

o Review the efforts of the state Medicaid program in providing maternal and child health services, and modify the program to improve care through expanded eligibility, enhanced services, improved outreach and marketing efforts, more appropriate provider reimbursements and other incentives to increase provider participation, and program revisions to make the system easier to access by clients.

o Review other health options for providing maternal and child health care, and develop state means to improve the effectiveness of those programs.

o Encourage greater coordination of service delivery among program service providers and seek to integrate, from the client's perspective, services available under Medicaid, WIC, MCHs, C/MCHs, and other providers of care.

o Develop means to assess the impact of each program initiative and its ability to meet the goals set for it.

A CHECKLIST FOR EVALUATING INDIVIDUAL STATE PROGRAMS

In the appendix of this guide is a checklist for legislators and policy makers to use in reviewing their own state's programs to improve maternal and child health services. This checklist identifies a variety of potential program initiatives, many of which are described in Chapters Four and Five of this guide. Not all the questions in this checklist will be answerable with a simple "yes" or "no" response. Legislators and policy makers are encouraged to solicit detailed comments from those asked to complete this checklist, and are encouraged to request a variety of agency personnel and child health advocates in their states to complete the checklist.

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APPENDIX.

LEGISLATOR'S CHECKLIST.

EVALUATING YOUR STATE'S MATERNAL AND CHILD HEALTH PROGRAMS

PART ONE: GENERAL STATE INFORMATION

	State	U.S. (1987)
1. Infant Mortality Rate (per 1000 births)		
All births	___	10.1
White	___	8.6
Black	___	17.9
Hispanic	___	7.9
2. Low Birthweight Rate (<2000 grams)	___	6.9%
3. % pregnant women receiving prenatal care in first trimester	___	76.0%
% pregnant women receiving prenatal care only in last trimester or no care	___	5.8%

	YES	NO
4. State goals established for improving prenatal health care and infant mortality rates	___	___

(If Yes. Describe.)_____

PART TWO: STATE MEDICAID PROGRAM EFFORTS

	YES	NO

1. Client Eligibility Characteristics

A. Pregnant Women and Infants to 185 % of Poverty ___ ___

(If No, % of Poverty _____)

B. Children aged six and seven up to 100 % of the federal poverty level ___ ___

(If No, Children to Age _____)

C. Eliminated Assets Test for Pregnant Women and Infants ___ ___
(If No, Asset Limitations _____)

D. Medically Needy Program ___ ___
(If Yes, % of AFDC Standard _ ___)

2. Easing Client Access to Medicaid

A. Presumptive Eligibility Established ___ ___

B. Priority Follow-Through on Eligibility Determination for Pregnant Women ___ ___

C. Continuous Eligibility for Perinatal Care ___ ___

D. Outstation Eligibility Workers in High Volume Locations ___ ___

E. Reduced Presumptive Eligibility forms to 3 or fewer pages ___ ___

3. Enhancing Services to Pregnant Women

A. Enhanced Case Management ___ ___

B. Enhanced Services for Pregnant Women:

Includes Risk Assessment ___ ___

Includes Nutritional Counseling	___	___
Includes Psycho-Social Counseling	___	___
Includes Outreach	___	___
Includes Home Visits	___	___
Includes Transportation	___	___
Includes Vitamin Supplements	___	___
Includes Sonograms/Amniocentesis	___	___
Does Not Restrict Physician Visits	___	___

4. Developing Marketing and Outreach Efforts

A. Special Outreach Program Efforts	___	___
B. Toll-Free 1-800 Number	___	___
C. Viable Media Campaign	___	___
D. Marketed in Positive Light (as opposed to "welfare stigma")	___	___

5. Increasing Provider Participation

A. Reasonable Physician Reimbursement for Prenatal Care Service Package	___	___
B. Supportive of Nurse Midwives and Nurse Practitioners	___	___
C. Reimburses Birthing Centers	___	___

6. Coordinating Medicaid with Other Programs

A. Integrated outreach and eligibility determination with other programs	___	___
B. Co-location to enable "one-stop" shopping	___	___

PART THREE: OTHER STRATEGIES TO IMPROVE MATERNAL AND CHILD HEALTH

1. Supporting Federal Maternal and Child

Health Programs

A. State funds to augment maternal and child health block grant ___ ___

B. Integration of Community and Migrant Health Centers with other State Delivery Systems ___ ___

C. Reimbursement rates for MCH and C/MHCs to capture maximum federal Medicaid Funds ___ ___

D. Active Medicaid recruitment at MCH centers and C/MHCs ___ ___

2. Supplementing the Federal WIC Program

A. State Funding to Expand WIC ___ ___

B. Contingency Funding or Other State Mechanism to Assure All WIC Funds are Expended and None Revert ___ ___

C. Substantial Rebate Program Established for Infant Formula ___ ___

3. Enhancing the EPSDT Program

A. Over 50 % of children on Medicaid Actually Receive EPSDT ___ ___

(If No, % Receiving EPSDT ____)

B. Computer Outreach Program to Identify Children Needing EPSDT ___ ___

C. Comprehensive Services Available As Part of EPSDT ___ ___

3. Supporting Home Visiting Programs

A. Home visits provided through Enhanced Services for Pregnant Women

and Through EPSDT ___ ___

(If Yes. Number allowed ____)

B. State funding support for community-based home visiting programs ___ ___

4. Expanding Provider Participation

A. Obstetrical shortage areas for Medicaid, all women identified in state ___ ___

B. Programs available to encourage physicians, nurse midwives, and nurse practitioners to serve underserved areas ___ ___

C. Barriers to availability of prenatal services as a result of malpractice insurance costs addressed ___ ___

D. Programs to support nurse midwives established ___ ___

5. Supporting Other Health Programs

A. General public programs provide prenatal care and child health care services at income levels above those allowed under Medicaid ___ ___

B. Fees for public programs kept affordable for prenatal care ___ ___

C. Public efforts integrated with private sector initiatives ___ ___

NOTE: Many of these questions will not be answerable with a simple "yes" or "no" response. Legislators are encouraged to solicit detailed comments from those asked to complete this checklist in their states, and are encouraged to request a variety of agency personnel and child health advocates to complete the checklist.

ADDITIONAL NOTES

The Child and Family Policy Center

The Child and Family Policy Center is a nonprofit organization linking research on children and families with public policy, dedicated to strengthening families and providing full developmental opportunities for children. The Center sponsors workshops, synthesizes and disseminates research findings to public policy makers, and conducts its own research initiatives. The Child and Family Policy Center was founded in 1989 as part of the Children's Home of Cedar Rapids Endowment Foundation.

Charles Bruner serves as Executive Director of the Child and Family Policy Center and is author of this guide. He has served twelve years in the Iowa General Assembly, the last eight as a state senator. He has authored numerous pieces of legislation on children and family issues and has written a number of articles and several books, including Slicing the Health Care Pie: A Legislator's View of State Health Care Allocation Choices. He holds a Ph.D. in political science from Stanford University and serves on a number of national boards and organizations.

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